

MEDICAL REQUEST FORM - Non- Prescribed Medications

Name of Child	
Date of birth	
Class	
Name of person completing this form	
(please print name)	
SECTION 1 – Medication Details	
Name of medication	
What has this been prescribed for?	
Does this medication contain aspirin? YES/NO	
If this medication contains	
paracetamol state the first date your	
child started taking this medicine IN THIS PARTICULAR EPISODE	
How much medication are you	
leaving (i.e. 20 tablets, one bottle	
etc) Dose needed (i.e 5ml, 10 ml etc)	
Dose needed (ne 3mm) 10 mm eto,	
Time/s you need this to be given to	
your child	
The last date medicine to be given	
Any adverse reaction we should look	
out for and action to be taken	

MEDICAL REQUEST FORM - Non- Prescribed Medications

I give permission for a member of school staff to administer this medication to my child as directed.

Signed parent)	
Date	

IT IS PARENTS RESPONSIBILITY TO COLLECT THIS MEDICINE FROM THE OFFICE AT THE END OF THE DAY.

SECTION 2 – Administration Details

Date	Time	Amount Given	Administered by